Allergy Asthma & Immunology Relief of Charlotte
PATIENT REGISTRATION FORM

LAST NAME: _____ MI :____ FIRST: _____

GENDER: M / F SSN: _____-_____-_____ DOB: _____ /_____ /_____

ADDRESS: _____ CITY: _____ST: _____ZIP: _____

HOME PHONE: _____ WORK/CELL: _____

RACE/ETHNICITY: _____ PREFERRED LANGUAGE: _____

EMPLOYER: _____

PATIENT EMAIL: _____ PHARMACY: _____

EMERGENCY CONTACT: _____

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN (IF DIFFERENT): _____

PRACTICE NAME/ADDRESS: _____

PERSON FINANCIALLY RESPONSIBLE: _____

RELATION TO PATIENT: _____ DOB: ____ / ____ / _____ SSN: _____-____-_____

ADDRESS (IF DIFFERENT): _____ CITY: _____ ST/ZIP: _____

"I authorize the release of any medical information necessary to process my/patient's insurance claim."

SIGNATURE: _____ DATE: _____

PRIMARY INSURANCE CO: _____

SUBSCRIBER (NAME ON CARD): _____ RELATION TO PATIENT: _____

SUBSCRIBER DOB: ____ / ____ /_____ SUBSCRIBER SSN: _____-____-_____

MEMBER ID: _____ GROUP: _____ CO PAY: $_____ EFFECTIVE_____

SECONDARY INSURANCE CO: _____

SUBSCRIBER (NAME ON CARD): _____ RELATION TO PATIENT: _____

SUBSCRIBER DOB: ____ / ____ /_____ SUBSCRIBER SSN: _____-____-_____

MEMBER ID: _____ GROUP: _____ CO PAY: $_____ EFFECTIVE_____